

wonderful occasion has aroused in me. Did I accept merely as a personal tribute these words of praise and this manifestation of appreciation and good will marked by this large and distinguished gathering and by meetings elsewhere, I should be overpowered with a sense of unreality depriving me of utterance, but I shall assume, as I feel that I am justified in doing, that by virtue of certain pioneering work and through over a half-century of service, I stand here to represent an army of teachers, investigators, pupils, associates, and colleagues, whose work and contributions during this period have advanced the science and art of medicine and public health to the eminent position which they now hold in this country. . . .

. . . As my immediate and, doubtless, final professorial interest is on the humanistic side of medicine, I may, in closing, be permitted to emphasize the attractions and importance of studies in the history of medicine and of science. We physicians apply the word "humanism" to a period and to a spirit which released the mind from thralldom to authority and contributed mightily not merely to the study of antiquity, but to the study of nature and of man, leading logically and rapidly to the cultivation of experimental science, between which and humanism as we understand and use the word, there is no incompatibility whatever.

While nothing can be more hazardous than to attempt to predict the directions of future discovery and progress in the biological and medical sciences, it requires no prophetic gift to be confident that with the widening of the boundaries of knowledge will come increased power to relieve human suffering, to control disease, to improve health and thereby add to the sum of human happiness and well-being. Your presence on this occasion and the widespread recognition, so conspicuously manifested, of the value of services rendered in the field of medical education and medical science are an encouragement to teachers and workers for which I am profoundly grateful and which accentuates the note of hopefulness which I have endeavored to sound.

CLINICAL NOTES AND CASE REPORTS

INFECTION WITH CRAIGIA*

REPORT OF CASE

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SINCE so much doubt has been cast upon the authenticity of the genus *Craigia*, we feel that every case should be recorded. Craig's¹ (1914) original organism and those of Barlow² (1915) have not been rediscovered, but Wenyon³ (1926) states that there is no doubt that Kofoid and Swezy⁴ have discovered a small flagellated ameba rarely found in human stools, and called by them *Craigia*. In Wenyon's³ opinion this uniflagellated ameba may belong to the genus *Spiromonas* or be similar to the coprozoic *Oikomonas*. Kofoid and Swezy⁴ (1921b) describe two species, *Craigia hominis* (Craig 1906) and *Craigia migrans* (Barlow 1915),² the latter being most commonly found. This species has in its life cycle (1) a swarmer or flagellate stage, (2) a motile ameboid stage, and (3) an encysted

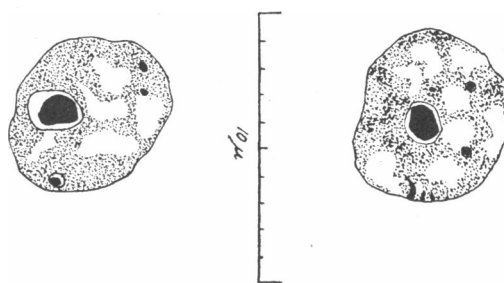


Fig. 1.—*Craigia* x 3600. Camera lucida drawings from slides stained with iron hematoxylin (Heidenhains).

stage which gives rise to swarmer flagellates. Cysts show a paradesmose at nuclear division, a condition only found in the flagellates. The flagellate phase is recognized at once by the single flagellum, the blepharoplast which appears as a small granule in the cytoplasm, occasionally a rhizoplast and a large nucleus with deeply staining karyosome. The spherical cysts can be distinguished from those of other amebae by the presence of the blepharoplast and the vacuolated cytoplasm which has a "smooth" rather than granular appearance. The nuclear membrane is very distinct, and the karyosome, although almost always a spherical mass, nearly fills the whole nucleus.

During routine examination of feces, we have encountered an organism (Fig. 1) corresponding in every way to that described by Kofoid and Swezy. This diagnosis was made from slides fixed in Schaudinn's fluid and stained with Heidenhain's iron hematoxylin. These showed organisms with the typical vacuolated cytoplasm, and one large nucleus with a deeply staining karyosome. Many forms showed the blepharoplast. The organism averaged 6.6 microns in diameter, a few being smaller.

No active flagellates, easily recognized by the single flagellum, were seen, and the fact that in seven subsequent examinations no protozoa of any kind were found, bears out the statement of Kofoid and Swezy that this organism is extremely erratic in its appearance in the stool.

Craig¹ (1914) claims no pathogenicity, except diarrhea which cleared with treatment. Barlow² (1915) attributes chronic diarrhea with hepatic abscess as a complicating symptom. Kofoid and Swezy⁴ have found the organism in cases of chronic diarrhea. Distribution of cases so far recorded is as follows: Philippines 9, United States 5, Honduras 60, Shanghai 4, Mexico 1, India, 1, Armenia 1. The case here reported from the service of Dr. A. C. Reed is of interest because of the complete lack of gastro-intestinal symptoms.

REPORT OF CASE

Miss G., female, white, age sixty-one, a nurse and teacher, entered the hospital on February 3, 1930, complaining of pain "under breasts" and ribs, and a productive cough.

Residence.—Richmond, Virginia, 0-12; England, Germany, and Mediterranean, 12-18; Philadelphia, 18-24; China and Japan, 24-31; Sydney, Honolulu, Samoa, and United States, 31-61.

* From the Pacific Institute of Tropical Medicine, University of California, San Francisco.

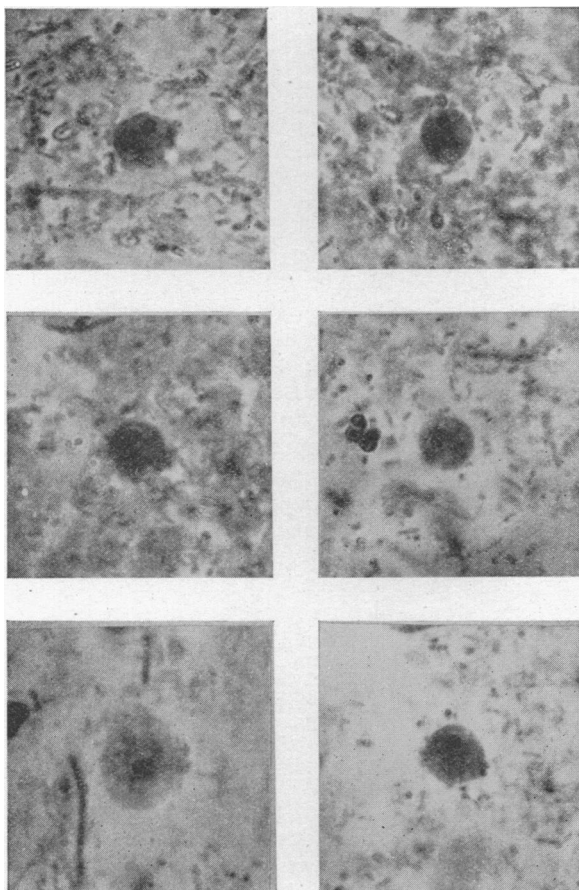


Fig. 2.—Craigia. Photographs from slides stained with iron hematoxylin.

Diseases.—Typhoid, aet. 21; exposure to tuberculosis in tropics; "influenza" last fall; colds frequently since.

Symptoms.—Headaches, "eyes bad," glasses for reading; occasional vertigo; no tonsillitis; occasional precordial pain; no dyspnea on effort; three pillows at night. Two months before admission the patient fell downstairs, injuring her left side, shoulder, and left eye. She developed a "cold" following this, which became progressively worse until January 9, when chest pain, cough—productive with rusty sputum and fever and weakness—became so marked that she went to bed and has been in bed since, treating herself as best she could in a hotel room. She has lost about twelve pounds in weight, and cough, fever, chest pain, weakness, and occasional vomiting persist to the present.

General Condition.—Temperature, 100; pulse, 100, regular; blood pressure, 145/70; respirations 30, and regular; poorly nourished; weight, 120 pounds; height, five feet five inches. She was very restless, coughing continually, raising sputum, and complaining of pain in left chest. The lungs showed pleuropneumonia, followed by bronchitis. The abdomen was not remarkable. There were no neurologic symptoms.

Diagnosis.—Bronchopneumonia; pleurisy; secondary anemia. X-ray of chest showed evidences of pleurisy with chronic bronchitis and enlarged hilus glands.

Laboratory Reports.—Urine: Clear, straw color, alkaline, specific gravity 1010; no albumin, no sugar, no casts, occasional pus cells, no blood. Sputum: Many pus cells, staphylococci, few short chains of streptococci, no acid-fast bacilli. Blood: Wassermann negative; hemoglobin, 75 per cent; erythrocytes, 4,180,000; leukocytes, 20,600; large lymphocytes, 8 per cent; transitional, 4 per cent; polynuclear neutrophils, 86

per cent. Feces: Neutral; occult blood negative; small amount of mucus; food well digested; few vegetable cells; few crystals; occasional muscle fibers; *Craigia* (ameboid stage).

Patient made a complete recovery, with no gastrointestinal symptoms at any time. Seven subsequent fecal examinations during hospitalization failed to reveal the presence of *Craigia*.

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DERMATITIS VENENATA DUE TO WIGANDIA CARACASANA

A HITHERTO UNRECOGNIZED CAUSE

REPORT OF CASE

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THE occurrence of dermatitis venenata, due to such plants as poison ivy (*Rhus toxicodendron*), poison oak (*Rhus diversiloba*) and other members of the *Rhus* family, as well as that due to the primrose, is too well known to require comment. A large number of both rare and common plants have been incriminated in the production of dermatitis venenata.¹

In reviewing the literature the authors have been unable to find any reference to a case of dermatitis venenata due to *Wigandia caracasana*, a fairly common tropical and subtropical plant which has been introduced into southern California and rather widely used as an ornamental shrub. Pardo-Castello² does not mention this plant in his list of tropical plants producing dermatitis venenata; nor is it mentioned in Weber's³ excellent list of cutaneous irritants. It is for this reason that the following case is reported.

REPORT OF CASE

Miss W. V., a nurse, age forty, was referred to us on July 14, 1930, by Dr. H. W. Wall. She complained of an itching, weeping eruption of one week's duration involving both upper extremities, especially the forearms, the face, and ears. According to the patient the skin condition began as a quarter-sized erythematous itching area on the lateral aspect of the right forearm. Calamin lotion was applied, but the eruption spread and became vesiculobullous in nature, with considerable oozing.

Past history was negative with the exception that the patient stated that she had had a dermatitis venenata due to poison oak when a child. Further that she had been compelled to give up her work as a surgical nurse several years ago because of hypersensitivity to bichlorid of mercury.

On examination the anterolateral aspects of both upper extremities, especially the forearms, presented a marked erythema. On the right forearm there were